Appendix A

Sources and Qualifications of Data from the Survey of Mental Health Organizations

The organizational data in chapter 18 were derived from a series of biennial inventories of special mental health organizations and non-Federal general hospitals with psychiatric services in the United States conducted by the Survey and Analysis Branch, Division of State and Community Systems Development, Center for Mental Health Services, with the cooperation and assistance of the State mental health agencies, the National Association of State Mental Health Program Directors, the American Hospital Association, and the National Association of Psychiatric Healthcare Systems. The data were imputed for missing organizations as well as for missing items among organizations that reported.

Prior to 1981–82, three inventories were conducted:

> Inventory of General Hospital Mental Health Services, which was used for non-Federal and Veterans Administration (VA) general hospitals identified as having separate psychiatric services.
>
> Inventory of Mental Health Organizations, which was used for organizations that were not covered in the other two inventories, including psychiatric hospitals (State, county, and private), VA neuropsychiatric hospitals and psychiatric outpatient clinics, psychiatric partial care organizations, and multiservice mental health organizations not elsewhere classified.
>
> Inventory of Comprehensive Federally Funded Community Mental Health Centers (CMHCs), which was used to monitor CMHCs fund under the CMHC Act of 1963 and pertinent amendments. This inventory was discontinued in 1981 when the definitions of organizations changed. All organizations surveyed in the CMHC Inventory were then subsumed under the other two inventories.

The 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services (IMHO/GHMHS) marked the beginning of a major evolution of the National Institute of Mental Health Inventory. For the prior 18 years, the biennial Inventory of Mental Health Organizations and the Inventory of General Hospital Mental Health Services functioned as companion, 100-percent enumeration surveys designed to collect information on specialty mental health organizations in the United States. They were carried out under separate contracts with separate forms, and in certain years, at different times of the year.

The 1986 IMHO/GHMHS was designed to simplify data collection procedures, reduce response burden, and alleviate many of the issues that had occurred prior to 1986. First, a single contract was awarded to conduct the IMHO/GHMHS. Second, since similarities existed between the questions asked in the previously conducted separate inventories, it was feasible to develop a common core form with three versions—one for specialty mental health organizations, one for general hospitals with separate psychiatric services, and a brief screener form for general hospitals with separate psychiatric services. Third, since the survey was carried out with a common core form, comparable information was obtained from general hospitals at the same time as from other specialty mental health organizations. The data collection protocol instituted in 1986 was also applied in 1988, 1990, 1992, and 1994.

In 1998, the IMHO/GHMHS was replaced by the Survey of Mental Health Organizations and General Hospital Mental Health Services, and Managed Behavioral Health Care Organizations (SMHO). The SMHO introduced several innovations: (1) the use of a brief 100-percent enumeration inventory (postcard form) that was sent to all specialty mental health organizations and non-Federal general hospitals with separate mental health services for the purpose of collecting core data and serving as a sampling frame for a more extensive sample survey; (2) the use of the sample survey form that was sent to a sample of specialty mental health organizations and general hospitals with separate mental health services; and (3) the use of a 100-percent enumeration inventory of managed behavioral health care organizations that provided minimal information on these entities for the first time and to serve as a sampling frame for sample surveys of these organizations in subsequent years.

The 1998 and 2000 data collections include two phases. The "Postcard inventory" uses the abbreviated version of past inventory forms that includes the types of organizations, ownership, the number of additions and resident patients at the end of the year, the number of episodes, and number of beds staffed during the reporting year. The second phase uses a sample survey form closely resembling the forms employed in previous inventories, but including more items addressed to managed behavioral health care.

Types of Information Collected

The inventories are typically mailed in January of even-numbered years to obtain information on the previous year. Organizations have the option of reporting on either a calendar or fiscal year basis.

For all years, the inventories include questions on types of services provided (e.g., inpatient, outpatient, and partial care) number of inpatient beds; number of inpatient, outpatient, and partial care additions; and end of year inpatient census, expenditures, and staffing by discipline. Revenues by source were collected only in 1983, 1986, 1988, 1990, 1992, and 1994 and in the sample survey for 1998 data.

Staffing information is collected as of a sample week at the time the inventory is mailed, and types of services and beds are collected as of the beginning of the next year. Thus, in tables where numbers of organizations and beds are shown, data are shown at a point in time, usually January of a particular year. For all other tables, the year refers to either the calendar year or a fiscal year. For all years, information is adjusted to include estimates for organizations that did not report.

Types of Services

Twenty-four-hour care refers to services provided in a 24-hour care setting in a hospital or 24-hour care in a residential treatment or supportive setting.

Less than 24-hour care refers to services provided in less than 24-hour care settings and not overnight.

Types of Organizations

Types of organizations included in this report are defined as follows:

An *outpatient mental health clinic* provides only ambulatory mental health services. A psychiatrist generally assumes the medical responsibility for all patients/clients and/or for direction of the mental health program. Beginning in 1986, the definition was changed so that for an organization to be classified as an outpatient clinic, it must provide only outpatient services. In 1994 and 1998, no differentiation was made between outpatient and partial care services. Any organization that was classified in previous years as either a freestanding psychiatric outpatient clinic, a freestanding partial care organization, or in some cases as a multiservice mental health organization with neither 24-hour inpatient nor residential services is now classified as an organization with less than 24-hour care services.

A *psychiatric hospital* (public or private) primarily provides 24-hour inpatient care to persons with mental illnesses in a hospital setting. It may also provide 24-hour residential care and less than 24-hour care, but these are not requirements. Included in this category would be hospitals under State, county, private for-profit, and private nonprofit auspices.

A *general hospital with separate psychiatric service(s)* is a licensed hospital under government or nongovernment auspices that has established organizationally separate psychiatric services with assigned staff for 24-hour inpatient care, 24-hour residential care, and/or less than 24-hour care (outpatient care or partial hospitalization) to provide diagnosis, evaluation, and/or treatment to persons admitted with a known or suspected psychiatric diagnosis. If 24-hour inpatient care is the separate psychiatric service, beds are set up and staffed specifically for psychiatric patients in a separate ward or unit. These beds may be located in a separate building, wing, ward, or floor, or they may be a specific group of beds physically separated from regular or surgical beds.

VA medical centers are hospitals operated by the Department of Veterans Affairs (formerly the Veterans Administration) and include VA general hospital psychiatric services (including large neuropsychiatric units) and VA psychiatric outpatient clinics.

Federally funded community mental health centers were funded under the Federal Community

Mental Health Centers Act of 1963 and the amendments thereto. In the early 1980's, when the Federal Government reverted to funding mental health services through block grants to the States rather than funding them directly, the Federal Government ceased to track these organizations. They are now subsumed in this report primarily under "all other mental health organizations."

A *residential treatment center (RTC) for emotionally disturbed children* must meet all of the following criteria:

- It must provide 24-hour residential services.
- It is an organization, not licensed as a psychiatric hospital, the primary purpose of which is the provision of individually planned programs of mental health treatment services in conjunction with residential care for its patients/clients.
- It has a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's or a doctorate degree.
- It serves children and youth primarily under the age of 18.
- The primary reason for the admission of 50 percent or more of the children and youth is mental illness that can be classified by DSM-IV/ICD-9-CM codes other than codes for mental retardation, drug-related disorders, or alcoholism.

All other mental health organizations includes freestanding psychiatric outpatient clinics, freestanding partial care organizations, and multiservice mental health organizations (i.e., organizations that provide services in both 24-hour and less than 24-hour settings and are not classifiable to other organizations such as psychiatric hospitals, general hospitals, or RTCs). In contrast to previous years, in 1994 and 1998 no distinction was made between outpatient and partial care on the inventory and the survey, and a category of "less than 24 hours and not overnight" was used.

Qualifications of the Data

Several factors affect the comparability of data. As a result of the 1981 shift in the funding of the CMHCs program from categorical to block grants, organizations that previously had been classified as CMHCs were reclassified as multiservice mental health organizations, freestanding psychiatric outpatient clinics, or separate psychiatric units of non-Federal general hospitals, depending on the types of services they directly operated and controlled.

Prior to 1983–84, any organization (1) not classified either as a psychiatric hospital, general hospital with separate psychiatric services, or residential treatment center for emotionally disturbed children and (2) that offered either inpatient care or residential treatment care and outpatient or partial care was classified as a multiservice mental health organization. In 1983–84, this definition was broadened to include organizations that offered any two different services and were not classifiable as any of the organizations noted (1) above. The provision of inpatient or residential treatment care was no longer a prerequisite. As a result, many organizations classified in 1981–82 and earlier with psychiatric outpatient clinics were classified in 1983–84 as multiservice mental health organizations. For partial care services, the definition was broadened to include rehabilitation, habitation, and education programs that had previously been excluded. This resulted in a sharp increase in the number and volume of partial care programs.

Other revisions occurred in the definition for psychiatric outpatient clinics. In 1983–84, an organization could be classified as a freestanding psychiatric outpatient clinic if partial care was provided as well as outpatient services. In 1986 through 1992, an organization had to provide outpatient services only to be so classified. In 1994 and 1998, both partial care and outpatient treatment were combined with multiservice to form the "other mental health organizations" category.

In summary, the net effect of the revisions has been to phase out CMHCs as a category after 1981–82; to increase the number of multiservice mental health organizations from 1981 to 1986; to increase the number of psychiatric outpatient clinics in 1981–82, but decrease the number in 1983–84, 1986, 1990, and 1992; and to increase the number of partial care services in 1983–84. These changes should be noted when interyear comparisons for the affected organizations and service types are made.

The increase in the number of general hospitals with separate psychiatric services was partially due to a more concerted effort to identify these organizations. Forms had been sent only to those hospitals previously identified as having a separate psychiatric service. Beginning in 1980–81, a screener form was sent to general hospitals not previously identi-

fied as providing a separate psychiatric service to determine if they had such a service.

The large increase in the number of RTCs between 1983 and 1998 was attributed to the identification of previously unknown RTCs from lists obtained in 1986.

Since 1981–82 data were not available for VA medical centers and non-Federal general hospitals, 1980–81 data were used where possible. For VA medical centers, 1980–81 data were available only on bed and patient movement variables for inpatient services. The effect on the comparability of the data resulting from the substitution of data for the previous year is unknown, but it is believed to be small. However, headnotes and footnotes indicate tables that have excluded VA data for all years and tables where data substitutions have been made.